Session 99 PD, Value Based Care Initiatives: Current Status, Major Trends and Future Changes

Moderator:
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The Policy Environment Driving Value-Based Care

Erik Johnson, Vice President
Optum Consulting
June 16, 2016
What Is Value-Based Care?

• While the concept of value-based care has existed for years, the passage of the Affordable Care Act accelerated its momentum in health care delivery.

• Value is typically measured by the Institute for Healthcare Improvement’s “Tripe Aim,” which includes an approach to manage the health of a population across the continuum of care. It measures:
  – Patient experience
  – Quality of care
  – Cost of care

• Value-based care is primarily a public policy driven concept, the economic objective of which is to reduce per capital health care resource utilization while maintaining or raising the level of quality.

• The shift from volume to value is really a shift from *negotiating and managing price* to *managing and reducing utilization*.
  – This is a massive cultural re-orientation for CFOs, managed care negotiators and actuaries.
Haven’t We Seen This Movie Before?

- Adoption of health IT at the bedside and in the office setting
- Development of value-based payment methodologies
- Advancement of clinical science
- An increasing willingness of physicians to seek employment arrangements with hospitals

Is this enough to guarantee a happy ending this time around?
To Achieve Value-Based Care, A Set of Coordinated Capabilities Are Necessary

1. Value-based Care Strategy & Governance

2. High Performance Network Management

3. Population Health Management & Quality

4. Enterprise Risk & Financial Management

5. Data Management

6. Consumer Engagement

7. Analytics & Reporting

8. Enabling Technology


10. Product Leadership

11. Organizational Change & Talent Acceleration
Provider Reimbursement Is An Enabler of Integrated Care

- Global payment/capitation
- Shared Risk
- Shared Savings
- Bundle payment (risk among providers)
- Bundle payment (single bearer of risk)
- Pay for performance
- Pay for activity/coordination
- Fee for service
- Payment for service or activity
- Attain measure targets
- Manage event/condition
- Manage a population

Value-based reimbursement

Degree of risk managed by provider

Level of provider sophistication and collaboration
Managing Episodes Does Not Equate to Managing a Population

**Episodic Risk**
- DRGs
- Bundled payment

**Population Health Risk**
- ACOs
- Capitation (MA Capitation, Commercial Capitation)

*Emphasis on efficiency and best practice*  
*Emphasis on prevention, eliminating episodes*
Success Is Not Easy: MSSP First and Second Performance Year

**First Performance Year – Results**
- **25%** ACOs generated savings
- **204** ACOs with reported results
- **53** ACOs generated total savings of $650 million
- **49** ACOs received $300 million
- **4** ACOs missed out on receiving $20 million
- **1** ACO had losses of almost $10 million

**Second Performance Year – Results**
- **28%** ACOs generated savings
- **333** ACOs with reported results
- **92** ACOs generated total savings of $800 million
- **86** ACOs received $341 million
- **6** ACOs missed out on receiving up to $15 million
- **2 of 3** Track 2 ACOs produced net shared savings
Employers Are Exploring New Strategies to Manage Health

- Rising costs and poor performance on quality indicators has prompted employers, health plans and government purchasers to push for a transition to value-based payment models

- Success of employer-based value-based care models depends on:
  - Size of covered population and leverage in specific markets
  - Effectiveness of narrow networks, access, consumer experience, and network size

81% expect to make changes to their health care strategy

68% expect to place restrictions on specialty drugs

61% are seeking value-based partners

50% expect to offer an Account-Based Health Plan as their only Option

63% expect to use spousal surcharges or exclusions

76% expect to use outcomes-based incentives

SOURCE: Towers Watson and Optum Analysis
Continued Growth of Public and Private “ACO-like” Models is Projected

The growth of ACOs in public and private programs has increased from 64 in 2011 to 744 in early 2015 (Figure 1).

Projected growth of ACOs will contribute to cover over an estimated 70 million people by 2020, and more than 150 million by 2025 (Figure 2).
CMS Has Been Driving Innovation For 10 Years

Setting the Foundation...

- **Measurement Regimes**
  - 2003: Hospital Inpatient Quality Reporting
  - 2006: Physician Quality Reporting System

- **Incentive for Infrastructure Development**
  - 2008: CMS Ceases Paying for Hospital Acquired Conditions
  - 2009: Affordable Care Act
  - 2010: Health Information Technology for Economic and Clinical Health Act
  - 2011: Meaningful use incentives

- **Payment and Delivery Reforms**
  - 2011: First generation of Medicare Shared Savings Program
  - 2012: Hospital Value-Based Purchasing and readmission penalties
  - 2013: Physician value-based modifier
  - 2014: Merit based incentive payment system and alternative payment models
  - 2015: ...Implementation Begins
The Era Of Value-Based Payment Is Already Here

Value-Based Payment Puts Nearly 9% of the DRG Payment at Risk

SOURCE: CMS

VBP = Value-Based Payment
HAC = Hospital Acquired Conditions
CMS Payment Innovation To Accelerate In Next Five Years, Followed By MA

Medicare
• By 2018, HHS is targeting 50% of Medicare payments though alternative payment models (APMs) and 90% through quality or value
  – APMs include ACOs, bundled payments and advanced primary care medical homes
  – CMS appropriated $10B per year for the next 10 years for innovation efforts
  – Nearly 7,000 organizations patriciate in BPCI

• Medicare Advantage (MA) plans are aggressively moving into value-based models; additionally, MA is experiencing significant growth, from 10 million enrollees in 2009 to expected 20 million in 2020

SOURCE: CMS, HHS
MACRA Components

- Repeals the SGR formula for Medicare PFS payment rates and substitutes a series of specified annual update percentages and creates 2 paths:

<table>
<thead>
<tr>
<th>Merit-based Incentive Payment System (MIPS)</th>
<th>Advanced Alternative Payment Models (Advanced APMs)</th>
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<tbody>
<tr>
<td>• Consolidates 3 existing programs: Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive program.</td>
<td>• A model under section 1115A of the Social Security Act (the Act) (excluding a health care innovation award), the Shared Savings Program under section 1899 of the Act, a demonstration under section 1866C of the Act, or a demonstration required by federal law.</td>
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<tr>
<td>• 2019 estimated 687,000-746,000 eligible clinicians</td>
<td>• Establishes the PFPTA Committee and promotes creation of PFPMs.</td>
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<td>• 2019 estimated 30,658-90,000 eligible clinicians</td>
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What is an Advanced APM?

- Accountable Care Organizations (ACOs)
  - Medicare Shared Savings Program Track 2
  - Medicare Shared Savings Program Track 3
  - Next Generation ACO
- Medical Home Models
- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model Two-Sided Risk Arrangement (2018)
Implications for Physicians under MACRA APMs

Taking Two-Side Risk + Collaborate with Hospital Partners

Annual Per Capita Benchmarks, Targets, and Actual Expenditures

- Historic Benchmarks (non-risk adjusted/trended)
- Beneficiary Expenditures (projected/actual)

BY1 | BY2 | BY3 | PY1 | PY2 | PY3

$8,500 | $9,000 | $9,500 | $10,000 | $10,500 | $11,000

Medical Center

Physician group

SNF/PAC providers
What We Expect MACRA to Drive

• The sheer administrative burden represented by MIPS indicates that CMS is stacking the deck in favor of APM selection

• While large physician groups are – theoretically – better situated to manage risk-based arrangements like ACOs, most will benefit from collaboration with capital- and staff-rich hospital partners to build out risk models
  – E.g., effective patient-centered medical homes often require clinical social workers, PA’s, pharmacy support and other clinical staff that most physician practices do not employ

• As a result – we expect that physician groups will seek “air cover” from local hospitals and health systems to bring either existing risk-based models or risk-based infrastructure to
Thank you & Questions

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Value Based Care Initiatives

June 16, 2016

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Elder
Care
Indigent
Care
Care of Others, e.g., Active Military, Veterans, & Government Workers
Public
(Defined by Function and Population Served)
Provider
Regulator
Payer
Indigent
Care
Care of Others, e.g., Active Military, Veterans, & Government Workers
Private
(Defined by Function)
Individuals and their advocates, e.g., NGOs and public interest groups
Public
Payers
- Health Plans
- Employers
- Purchasers
- ERISA Plans
- Coalitions
- Charities
Provider
Payers
- Health Plans
- Employers
- Purchasers
- ERISA Plans
- Coalitions
- Charities
Suppliers, e.g., Pharma, Biotech, Devices, Equipment
Providers, e.g., MDs, Hospitals, SNFs, Pharmacies
Stakeholders

Source: Joel Shalowitz, MD, MBA ©2004, 2008
EXAMPLES OF CROSS-CATEGORY STAKEHOLDERS

News Summary: On-Site Clinics Gain Popularity With Employers

AHIP HI-WIRE  Douglas Schulz  May 02, 2011

Roughly one-quarter of large companies in the U.S. have an on-site clinic and the number of such clinics is expected to grow by at least 15% per year over the next 5 years. In many ways, on-site clinics are an example of the use of preventative services to improve long-term health and thus reduce the use of more intensive and expensive medical services in the future.


United Airlines Opens Free Workplace Health Clinic At O'Hare

CLINIC MANAGED BY WALGREENS PROVIDES BROAD SCOPE OF HEALTH CARE SERVICES TO UNITED EMPLOYEES  PR Newswire  (http://s.tt/1yDP2)

CHICAGO, Jan. 18, 2013 /PRNewswire/ -- United Airlines today announced the opening of the airline's new employee health clinic at O'Hare International Airport. The clinic, managed by Walgreens, will serve a broad scope of employees' health needs, such as urgent care for routine illness, travel and other immunizations including flu shots, prepackaged medications, job-related physical training and pre-employment physicals, at no cost to employees. The convenient access to these and other health care services is available to all United employees, including the more than 10,000 co-workers in the Chicago area...
Insurer-owned clinics seek to improve health care, curb costs
May 04, 2011 | By Christopher Weaver, KAISER HEALTH NEWS

Every few months, James S. Miller, a 68-year-old retired transit worker and jazz saxophonist, would arrive by electric wheelchair at North Philadelphia hospital emergency rooms, short of breath and with the swollen legs that mark his illness, congestive heart failure...
That went on for years, until Miller enrolled last September in a private Medicare plan, Bravo Health, with a financial interest in keeping him well. Today, he has swapped the woes of the ER for the advantages offered at the Bravo Health Advance Care Center on Lehigh Avenue, where there are flat-screen TVs, 10-minute waits, and medical care delivered by doctors whom his insurer employs at no cost to patients.

The insurer launched the clinic in January 2010 and has opened two more since - one in West Philadelphia and one in Baltimore. By giving urgent care, working longer hours, welcoming walk-ins, and offering care such as IV therapy that is not available at most doctors' offices, the clinic can keep patients from running up big hospital bills.
Anthem hatches another hospital joint venture, this time in Wisconsin

By Bob Herman April 20, 2016 Modern Healthcare

Anthem's Wisconsin subsidiary and Aurora, a 15-hospital system based in Milwaukee, will each own 50% of Wisconsin Collaborative Insurance Co., a newly licensed insurer. The joint venture somewhat resembles Vivity, the health insurance product created in September 2014 by Anthem's California subsidiary and seven Southern California health systems, including academic medical centers Cedars-Sinai and UCLA...

Only Anthem and Aurora split the profits and losses 50-50, but Aurora is not the only provider system within the network...

Aside from Aurora, several other health systems scattered throughout the state will be part of the network: Aspirus, Bellin Health, Children's Hospital of Wisconsin, Gundersen Health System, ProHealth Care, ThedaCare, UW Health and UnityPoint Health-Meriter, along with some other clinics and physician groups. None of those systems outside of Aurora has an ownership stake in the new insurer, and many are involved in a separate provider alliance called About Health. But like Vivity, the joint venture blends elements of HMOs and accountable care organizations...
Humana and Astellas Form Research Collaboration to Improve Health Care Delivery for Seniors

LOUISVILLE, Ky. & NORTHBROOK, Ill. February 19, 2013 --(BUSINESS WIRE)--Humana Inc. (NYSE: HUM), one of the nation’s leading health and well-being companies, and Astellas Scientific and Medical Affairs Inc., a U.S. subsidiary of Tokyo-based Astellas Pharma Inc. (Tokyo: 4503), today announced a multi-year research collaboration to explore new ideas and ways to improve the health and well-being of patients and members.

“Through this important collaboration, we’ll use clinical data to conduct comparative effectiveness research to evaluate ways to improve healthcare and health outcomes for patients.”

The two companies will bring together researchers and health care experts from both companies to study key issues and develop ways to reduce inefficiencies in the management of oncology, urology and immunology conditions. ..
Pa. insurance department OKs Highmark-West Penn deal

Highmark won approval from Pennsylvania's Insurance Department to acquire West Penn Allegheny Health System, removing a major barrier to a nationally watched bid by one of the largest U.S. insurers to diversify into healthcare delivery.

State insurance regulators set conditions on approval for the deal, which was required for the transaction to proceed. The deal was first announced in June 2011 and submitted for approval in November 2011.

Conditions set by the Insurance Department require a firewall policy to prevent Highmark and West Penn from sharing rivals' pricing or product information, which could reduce competition, the agency's order said. Conditions also prohibit exclusive contracts by Highmark's hospitals, doctors or other providers or contracts longer than five years. The regulator also banned use of deals that guarantee insurers the best terms or price, known as “most favored nation” clauses…
Geisinger, one of the largest integrated health systems in the United States serving approximately three million residents, signed an agreement to partner with Regeneron, a biopharmaceutical company based in Tarrytown, N.Y., that discovers, invents, develops, manufactures and commercializes medicines to treat serious medical conditions...

During the initial five-year collaboration term, Geisinger plans to collect samples from more than 100,000 consented patient volunteers.

Regeneron, through its subsidiary Regeneron Genetics Center LLC, will perform what officials describe as "genetic sequencing" on the samples and analyze records to identify associations between genes and human disease...
Medtronic Expands Into Disease Management
Acquisition of Cardiocom Fits With New Law's Push to Reduce Hospital
The Wall Street Journal August 11, 2013

By CHRISTOPHER WEAVER

Medtronic Inc. said it has acquired Cardiocom LLC, a closely held disease-management and patient-monitoring firm, in a move that the device maker hopes will turn increasing concerns about health spending to its advantage.

The $200 million, all-cash deal puts Medtronic in the business of working with hospitals and insurers to limit the costs of treating patients with chronic diseases, such as heart failure and diabetes, and gives it a hand in the care of patients who don't need costly, high-tech implantable devices that are Medtronic's core offerings.

Cardiocom's products, such as home glucose monitors for diabetics and weight scales that help doctors detect early signs of worsening heart failure, could get a boost from a new health-law rule that penalizes hospitals when their patients return within a month of discharge.
Strategic Choices to Deliver Healthcare Stakeholder Value

Low Cost = Cost

Total Solution = Access

Best Products = Quality
How do we put together the concepts of value tradeoffs and stakeholder identification into formulating stakeholder value strategies that also maximize value for the firm?
A. COST

WHAT ARE THE COMPONENTS OF COST? HOW ARE THEY RELATED TO ONE ANOTHER?
WHAT ARE THE TRADEOFFS?

- Supplier/ Provider
- Payer / Regulator
- User

Demand
Supply

Volume
Price

Intensity of Service
Level of Service

Number of Components Per Service Episode, e.g., Pills per Treatment
Efficiency of Service e.g., LOS, Duration of Product Use

Decision to Perform Service Or Use Product

Cost Shifting
Who Pays, e.g., Government Mandates For Payment and Buyer Power

Volume
Production Cost

Who Pays, e.g., Government Mandates For Payment and Buyer Power

Other

Level of Service
Site of Service

Inpatient
Outpatient

Physician Office
Home

Physician Office

Other, e.g., Surgicenter, Dialysis, Lab

Other, e.g. SNF

Number of Components Per Service Episode, e.g., Pills per Treatment

Efficiency of Service e.g., LOS, Duration of Product Use

Access

Quality

Source: Joel Shalowitz, MD, MBA © 2004
What Drives U.S. Pharmaceutical Costs?

• **Price**
  
  The average annual growth in prescription drug prices from 2000 to 2009 was 3.6 percent, compared to 4.1% for all medical care and 2.5% for all items.

• **Volume**
  
  From 1999 to 2009, the number of prescriptions increased 39% (from 2.8 billion to 3.9 billion), compared to a US population growth of 9%.

• **New medications replacing older ones**
  
  Prescription drug spending is affected when new drugs enter the market and when existing medications lose patent protection. Almost 80% of FDA-approved drugs have generic counterparts. In 2008, 22% of total prescription drug sales and 72% of total prescriptions dispensed were generic medicines. Several high-sales brand name drugs are expected to go off-patent in the next 5 years, peaking in 2011 and 2012 when 6 of today’s 10 largest products in the U.S. are expected to face generic competition. While total drug sales may decline as a result, the competition from generic drugs may bring down costs for patients.

Source: Kaiser Family Foundation. Prescription Drug Fact Sheet, May 2010
http://www.kff.org/rxdrugs/3057.cfm
Spearman’s Correlation Coefficient = .21 (CI = 95%, p = .07)
Patient satisfaction was independent of hospital compliance with surgical processes of quality care and with overall hospital employee safety culture, although a few individual domains of culture were associated. Patient satisfaction may provide information about a hospital's ability to provide good service as a part of the patient experience; however, further study is needed before it is applied widely to surgeons as a quality indicator.
Many five-star hospitals scored low on other measures
By Sabriya Rice | May 2, 2015 | Modern Healthcare

A large percentage of hospitals that received Medicare’s top five-star rating on patient satisfaction were penalized for excessive readmissions or fared poorly on curbing hospital-acquired conditions, a Modern Healthcare analysis shows.

Of 151 five-star hospitals on which data were also available for three other CMS quality programs, 39% received a penalty for excessive 30-day readmissions. In addition, 47% received a score of 5 or higher for hospital-acquired conditions (HAC) on a 1-10 scale where 1 is the best. The remaining 100 five-star hospitals did not have fiscal 2015 data reported for the other CMS quality programs.
C. Access/Equity

Who Accepts Insurance?

Who Is Not Covered? (How Many Can/Does A Society Tolerate?)

Who Has Coverage?

What is covered?

When is care provided? i.e., How fast?

Where (Distance and Availability, Including of Transportation)

Scheduling/Rationing

Who? 16

Products/Equipment 18

Services

Providers

Access/Equity

Availability

INFRASCTURE 15

Services

Products/Equipment

Providers

Funding

High Level Commitment

SUSTAINABILITY 22

Resources

Products/Equipment

Providers

Cost

Quality

Source Joel Shalowitz, MD, MBA ©2004
6 Key Questions:

• Who are your stakeholders?

• What is their relative importance to you?
  a) Given a specific issue/product [Short term]?
  b) Overall [Long term]?

• What are your stakeholders’ value propositions? (3D thinking)

• Who are your stakeholders’ key stakeholders?

• How can you help your key stakeholders deliver value to their key stakeholders?

• How do your stakeholders prioritize your importance to them?
Glaxo chief seeks guidance from health systems

 Reuters - Pharmaceutical giant GlaxoSmithKline plans to give government healthcare systems a say in deciding which drugs advance in its research pipeline, Chief Executive Andrew Witty told The Wall Street Journal.

The effort is part of Witty's drive to help the world's second-largest drug maker adapt to a tough pharmaceutical market, the newspaper said...

A few weeks ago, Glaxo's chief of research and development invited a group of healthcare officials from the UK, France, Italy and Spain to London to examine the drugs the company was developing.

"(It) was an opportunity for us to say, 'Look, here's what the development pipeline at (Glaxo) looks like, here's what these drugs are going to be...which one of these do you think?' This is exactly where I would prioritize healthcare dollars," Witty was quoted as saying.

The officials who were mostly looking at the drugs Glaxo was testing in small, intermediate human trials, gave blunt feedback on which drugs to prioritize and what sort of data Glaxo would need to show to make state healthcare systems willing to buy the drugs, Witty told the paper...

(Reporting by Ajay Kamalakaran in Bangalore, Editing by Jacqueline Wong)

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Sanofi’s Zerhouni On Translational Research: No Simple Solution

When former NIH head Elias Zerhouni ran the $30 billion federal research institute, he pushed for so-called translational research in which findings from basic lab research would be used to develop medicines and other applications that would help patients directly.

Now the head of R&D at French drug maker Sanofi, Zerhouni says that such “bench to bedside” research is more difficult than he thought…

There needs to be a “re-do” in pharma R&D, Zerhouni said.

At Sanofi, the goal now is to strive for “open innovation,” which involves looking for new research and ideas both internally and externally — for example, at universities and hospitals. In addition, the company is focusing on first understanding a disease and then figuring out what tools might be effective in treating it, rather than identifying a potential tool first and then looking for a disease area in which it could be helpful...
Pharmaceutical companies must move towards new pricing models based on outcomes for patients if Europe’s cash-strapped health systems are to remain solvent, according to the chief executive of Novartis. Joe Jimenez warned that companies could no longer expect to be rewarded for medicines that produce weak benefits or only incremental improvement over existing treatments in an era of rising pressure on health budgets.

“What’s coming is not a pretty picture for anybody in the next 10 years and unless we... help reduce demand on the health system it is just going to mean more cost containment, more rationing of care and that’s not good for the industry,” he said...

His views reflect growing consensus that drug companies must shift away from traditional business models based on maximising volume regardless of how well their medicines worked. In future, said Mr Jimenez, industry should be rewarded for positive patient outcomes and the value provided to societies.
Virginia Mason plans to cover the costs of avoidable, surgery-related complications if a patient undergoes all of his or her care, including diagnosis, surgery and rehabilitation at the hospital, and is covered by a bundled-service contract with a private insurer or employer. The timeframe for the warranty would be negotiated with the understanding that most complications occur within 90 days of the surgery, a hospital spokesman said. The warranty does not cover complications or revisions resulting from the failure of an implant itself…

Geisinger Health System, a four-hospital system based in Danville, Pa., was the first system in the nation to offer surgical warranties through its ProvenCare model. Geisinger starting providing warranties on elective cardiac surgery in 2006, and on Monday it plans to announce that its program has been expanded to cover the costs of hip fractures and total hip and knee replacements…
Health Insurers Push to Tie Drug Prices to Outcomes
By PETER LOFTUS and ANNA WILDE MATHEWS  Wall Street Journal  May 11, 2016

…Cigna announced on Wednesday that it is the first insurer to reach value-based contracts for an entire new class of cholesterol drugs: Praluent, which is co-marketed by Sanofi SA and Regeneron Pharmaceuticals Inc., and Amgen Inc.’s Repatha are the only two cholesterol-lowering drugs known as PCSK9 inhibitors currently on the U.S. market.

If Cigna-insured patients who take the drugs aren’t able to reduce LDL cholesterol at least as well as what was shown in clinical trials, the manufacturers will further discount the costs of the drugs—and not just for patients who didn’t meet the cholesterol goals. If the drugs meet or exceed expectations, the original negotiated price stays, according to Cigna.

Health insurers and pharmacy-benefit managers have signed at least a dozen such deals with drugmakers since 2014, including Cigna, Harvard Pilgrim Health Care and Express Scripts Holding Co., targeting high-cost drugs in categories including cancer and hepatitis C…

Drugmaker AstraZeneca PLC signed a deal last year with Express Scripts to reimburse costs of the lung-cancer drug Iressa if a patient stops treatment before the third prescription fill. And Eli Lilly & Co. has a deal with insurer Humana Inc. that ties the level of reimbursement for the heart drug Effient to the rate of hospitalizations among patients who take it…

CVS Health Corp., the second-biggest U.S. pharmacy-benefit manager, has also made deals that tie payment to patient outcomes.

Potential problems:
1. Long time to see if the drug succeeded (EX: Cardiovascular mortality)
2. Verify the data from vendor and purchaser (EX: How well drug is supposed to work; verify patient was taking it faithfully)
C. Bundled/Packaged Services

Two value propositions:

1. Predictable costs
2. Reduced administrative expenses
United offers employees cheaper hip, knee replacements if they travel to Chicago's Rush University Medical Center

The airline is encouraging workers across the country and their families to go to Rush University Medical Center in Chicago for hip and knee replacements as well as spinal fusion surgeries. To entice them, United is offering a generous benefit: The expenses for physician visits and the surgery are fully covered by United after employees meet the annual deductible on their insurance policies. There are no copays or coinsurance… United also pays for the employee and a companion to travel for the surgery, and recommends two guest houses that are on or near the Rush campus... United hopes that by partnering with a hospital with a track record of proven orthopedic care, workers will receive better care and have fewer complications afterward. If the surgery goes well, employees can return to work faster and save the company money by eliminating readmissions to the hospital...

The airline also negotiated a deal with Cleveland Clinic for certain heart procedures...

Pacific Business Group on Health… created a program in 2013 it calls the Employers Centers of Excellence Network that offers free hip- and knee-replacement surgeries at four prestigious hospitals in the country. Four companies are participating in the program: Wal-Mart, Lowe's, JetBlue and McKesson...

Northwestern Memorial Hospital negotiated a contract with General Electric in 2014 to do hip and knee replacements for its employees… a majority of the GE-affiliated patients that come to Northwestern live at least 50 miles from the hospital...

University Hospitals will provide joint replacement care to GE health plan members

By Lydia Coutre, Crain's Cleveland Business | June 3, 2016

General Electric has selected University Hospitals, Cleveland, to provide joint replacement surgery to eligible out-of-state health plan members. The National Hip and Knee Replacement Centers of Excellence program gives members who live out of the area the option to travel to Northeast Ohio for surgery at UH Case Medical Center or UH Conneaut Medical Center, according to a news release.
And finally...

How do we combine cost, quality and access considerations to assess *value as the customer defines it*?

Competing sample definitions:

*Given a certain cost, how can I maximize quality?*

*Given a desired quality, how can I minimize cost?*